STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX **File No. 85786-001**
Petitioner
v

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 18th day of December 2007
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On October 17, 2007, XXXXX (Petitioner) filed an incomplete request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. After additional information was provided, the Commissioner reviewed the request and accepted it for external review on November 8, 2007.

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on November 16, 2007.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM *Comprehensive Health Care Copayment Certificate Series CMM 100* (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner became ill in November 2006 and was confined at XXXXX on December 1, 2006. The services in question were provided from December 2 to December 4, 2006, by XXXXX, a nonparticipating provider (i.e., it has not signed an agreement to accept BCBSM's approved amount as payment in full). BCBSM paid $1,223.15 of the $3,461.00 charged by XXXXX. This left the Petitioner to pay the balance of $2,237.85.

The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on September 19, 2007, and issued a final adverse determination dated September 25, 2007.

III
ISSUE

Is BCBSM required to pay an additional amount for the care provided the Petitioner by XXXXX?

IV
ANALYSIS

Petitioner's Argument

The Petitioner says he was gravely ill in November 2006 with a fast acting staph infection that put him in the hospital, and that it took a few days to figure out his problem. The specialists from XXXXX who treated him were provided through the hospital and do not participate with BCBSM.

At the time, the Petitioner says he was "going down hill very fast" and he did not ask the treating doctors if they were participating. The staph infection gave him terrible throbbing headaches and sweats and he was "pretty much out of it" from the infection. He says he would have asked about the doctors' participation status if it had been a routine medical problem and he had been in a better position to address his situation.

The Petitioner feels that BCBSM should pay more on this claim because it was a life and death situation and he was treated by the doctors provided by the hospital. He does not think it fair that he is required to pay such a large balance for his care.

BCBSM's Argument

BCBSM says that Section 4 of the certificate, *Coverage for Physician and Other Professional Services,* explains how it pays its "approved amount" for physician and other professional services -- the certificate does not guarantee that charges will be paid in full.

The amounts charged by XXXXX and the amounts paid by BCBSM for the December 2006 care are set forth in this table:

Date of Service	Procedure Code	Amount Charged	BCBSM's Maximum Payment Amount	BCBSM's Approved Amount	Amount Paid by BCBSM	Petitioner's Balance
12/02/06	99252	$ 164.00	$ 90.21	$ 90.21	$ 0.00[1]	$ 164.00
12/03/06	99231	$ 83.00	$ 42.51	$ 42.51	$ 42.51	$ 40.49
12/04/06	27625	$ 2,076.00	$ 758.04	$ 758.04	$ 758.04	$ 1,317.96
12/04/06	23120	$ 1,138.00	$ 845.21	$ 845.21	$ 422.60[2]	$ 715.40
	Totals	$ 3,461.00			$ 1,223.15	$ 2,237.85

Since the Petitioner's doctors did not participate with BCBSM, they are not required to accept BCBSM's approved amount as payment in full.

In determining the maximum payment level for each service, BCBSM says it applies a Resource Based Relative Value Scale (RBRVS), a nationally recognized reimbursement structure developed by and for physicians. The RBRVS reflects the resources required to perform each service. BCBSM regularly reviews the ranking of procedures to address the effects of changing technology, training, and medical practice. There is nothing in the certificate that requires BCBSM

[1] The $90.21 approved for procedure code 99252 was applied to the Petitioner's annual deductible requirement.

[2] BCBSM pays 50% of its approved amount for the less costly procedure when multiple surgeries are performed on the same day by the same physician through different incisions.

to pay any additional amount even if the care was provided for a life-threatening condition or even if there were no participating provider to provide the care.

BCBSM believes that it has paid the proper amount for the Petitioner's care by nonparticipating providers and is not required to pay any additional amount.

Commissioner's Review

The certificate describes how benefits are paid. It explains that BCBSM pays an "approved amount" for physician and other professional services. The approved amount is defined in the certificate as the "lower of the billed charge or [BCBSM's] maximum payment level for a covered service." Participating and panel providers agree to accept the approved amount as payment in full for their services. Nonparticipating providers have no agreement with BCBSM to accept the approved amount as payment in full and may bill for the balance of the charges. The certificate says (on pages 4.22):

> **NOTE**: Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

BCBSM paid for the Petitioner's surgery of December 4, 2006, based on BCBSM's full approved amount for the most costly procedure and one-half of the approved amount for the less costly procedure. This practice is based on a national standard recognized by BCBSM and is included in the terms of the certificate.

It is unfortunate that the Petitioner was in a situation where he was not able to use participating doctors. Nevertheless, there is nothing in the terms and conditions of the Petitioner's certificate that requires BCBSM to pay more than its approved amount to nonparticipating providers even if the surgery was provided for a life-threatening condition or if no participating providers were available.

The Commissioner finds that BCBSM has paid the Petitioner's claims correctly according to the terms of the certificate and is not required to pay more for the Petitioner's care.

V
ORDER

BCBSM's final adverse determination of September 25, 2007, is upheld.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.